JOINING THE CIRCLE:

An Aboriginal Harm Reduction Model

A Guide For Developing
A Harm Reduction Program In Your Community:
Phase I

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The Issue

- Due to colonization, poverty, and racism, Aboriginal people are over-represented among Canadians who use injection drugs. An unfortunate aspect of injection drug use is that the use of needles places people at an increased risk of HIV infection.

- Aboriginal injection drug users (IDUs) are the fastest growing group of new HIV cases in Canada.

- According to our survey, as many as 79% of Aboriginal IDUs visit their Reserve with some frequency. While on their Reserve, they may share needles or have unprotected sex with community members.

- Very few Reserves in Canada have condom distribution and/or needle exchange programs to reduce the risk of HIV transmission between people in the community. Education about HIV/AIDS remains low on many Reserves.

- If the prevalence of HIV increases among Aboriginal people, a major HIV epidemic will occur where the virus is primarily spread by sex between Native men and women.

- According to our survey, as many as 87% of Aboriginal IDUs have been incarcerated, often for drug-related crimes.

- Drug use within the penal system is a fact of life, but there is no program for providing clean needles in prison. Thus while in prison, Aboriginal IDUs are unable to protect themselves against HIV infection.

- Although Aboriginal IDUs interact with three communities (the streets, the Reserve and prison), only urban agencies have developed programs to reduce HIV transmission by injection drug use and sex.

Highlights of an Approach to Harm Reduction

- Given the mobility of Aboriginal IDUs, the entire Aboriginal community -- from the Reserve, to the streets, to prisons – needs to pull together and implement programs to reduce the risk of HIV infection to Aboriginal IDUs and prevent an epidemic within the greater Aboriginal community.
- Until recently, most people sought to abolish illegal injection drugs while others lobbied to decriminalize these drugs. There was no middle ground.
- To address the serious issue of HIV spreading by injection drug use, Health Canada endorses a new approach which they call "Harm Reduction".
- Harm Reduction is a pragmatic middle-ground approach which recognizes that injection drug use is inevitable and seeks to help IDUs reduce the risk of infection while they are using – thus prevent the spread of HIV.
- The Harm Reduction model has 4 major components: 1) Needle exchange programs; 2) condom distribution; 3) methadone maintenance treatment; and 4) counseling.
- The Harm Reduction model is built on respect. It is a non-judgmental approach designed to help IDUs make informed choices.
- The Government of Canada has legalized needle exchange programs to prevent the spread of HIV. Provincial and federal health programs finance methadone treatment to help people stop their heroin addiction.
- Many injection drug users quit using drugs and take up new roles in society. Harm Reduction is designed to reduce the risk of HIV infection while people are using drugs.
- We want to keep Aboriginal IDUs healthy until they rejoin our communities.
- This package is designed to help Community Health Representatives (CHRs) and other Aboriginal health programmers learn more about Aboriginal injection drug use and develop a Harm Reduction program for your community.
- We need to address the risk of an HIV epidemic on all fronts while respecting our IDU people; helping them make informed choices about staying healthy; and reducing the risk of HIV infection to themselves and the community.

Executive Summary

The transmission of HIV through injection drug use (IDU) has reached crisis proportions in Canada. Rapidly increasing HIV rates among Aboriginal injection drug users (IDUs) is most striking. Aboriginal people in Vancouver make up a disproportionate number (27%) of the city's IDU population and are more likely than non-Native IDUs to become infected with HIV. As well, as many as 87% of Aboriginal IDUs spend time in prison where there is a high prevalence of HIV, but prison officials do not give inmates all the necessary means to protect themselves against infection.

Because as many as 79% of Aboriginal IDUs visit their Reserve community where they may have sex and share needles, the issue of HIV and Aboriginal IDU is not limited to urban streets, but is also a Reserve problem.

There are three Aboriginal communities involved in the issue of HIV and injection drug use: the urban Aboriginal street population, the Reserve population and Aboriginal people in Canadian prisons. All three communities need to act. Failure to react to the issue of Aboriginal IDU and HIV may lead to the spread of HIV throughout our community.

As the HIV epidemic evolves from being a virus affecting only the gay community, we the Aboriginal people, are the next group of people in Canada most vulnerable to a general HIV epidemic. If we do not respond, we will be severely impacted. CAAN recommends a Harm Reduction model.

The Harm Reduction approach is a pragmatic, non-judgmental approach to drug use which focuses upon reducing the harm caused by drugs. The four mainstays of the Harm Reduction model are: needle exchange programs, condom distribution, methadone maintenance treatment and counseling. The implementation of a Harm Reduction program does not necessarily mean you condone drug use, but rather, offers a pragmatic solution to stopping the spread of HIV.

In order to better understand and communicate the issues and needs of Aboriginal IDUs, the Canadian Aboriginal AIDS Network (CAAN) has conducted a survey among 126 Aboriginal IDUs in various Canadian cities and prisons. The survey identifies the social and economic profile of Aboriginal IDUs, their needs and the barriers which prevent them from accessing social and health services. This report also synthesizes a series of government reports and medical studies on injection drug use in Canadian cities and prisons.

This CAAN survey reveals a group of Aboriginal people who are severely economically depressed, with low levels of formal education and who live in unstable housing or on the streets. Many have ended up on the streets as a partial result of abuse and neglect during their childhood. The majority (87%) have spent time in jail and 71% of the women are involved in prostitution. According to all the means by which we can predict HIV infection, these people are at great risk of acquiring HIV. The respondents indicate that they do not want to contract HIV and where Harm Reduction services are made available, most have changed their risk behaviours in order to reduce their chance of HIV infection.

Over two thirds of the respondents have tried to stop using injection drugs. Those who quit and remain HIV negative will have a chance to take up new roles in the Aboriginal community. The goal of this project is to empower Aboriginal IDUs to make informed decisions about behaviour change and reduce their risk of HIV infection and to prevent the spread of the virus into other parts of the Aboriginal community.

Better services and information will also help to reduce the chances of Aboriginal youth deciding to start injecting drugs. HIV/AIDS information will also educate community members about the risks of HIV infection through unprotected sex.

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Appendix A: Board of Directors, Canadian Aboriginal AIDS Network

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAAN	Canadian Aboriginal AIDS Network
CAS	Canadian AIDS Society
CHALN	Canadian HIV/AIDS Legal Network
CHR	Community Health Representatives
CSC	Correctional Services Canada
ECAP	Expert Committee on AIDS in Prisons
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
MMT	Methadone Maintenance Treatment
MSM	Men who have Sex with Men
NEP	Needle Exchange Program
PHA	Person with HIV/AIDS
STD	Sexually Transmitted Disease
T&R	Talwin and Ritalin

1.0 Introduction

1.0 Introduction

1.1 The Problem:

The problem is simple: an HIV epidemic threatens all Aboriginal people and immediate action by all Aboriginal communities (Reserve, urban, prison) is necessary.

Health Canada officials, medical researchers and Aboriginal AIDS experts have observed that HIV is spreading through a new group of people: Aboriginal injection drug users (IDUs). The concern is that HIV can be transmitted by blood in needles among people who share needles. "When people inject drugs, some blood is pulled back into the needle and syringe. If the equipment is shared, that blood is then shot into the bloodstream of the next person in line. If someone infected [with HIV] is taking a turn, the virus will likely be passed on."[1]

"The situation is serious."[2] The number of Canadian adults who have identified injection drug use as a risk factor for HIV infection has doubled from 4% in 1987 to 8% today. Health Canada reports that "...in 1996, approximately half of the estimated 3,000-5,000 HIV infections which occurred in Canada were among injection drug users."[3] In Montreal, there are five new infections for every 100 IDUs[4] and in Vancouver, the rate those now testing HIV positive because of injection drug use has increased from 9% to 38%.[5] Among Aboriginal people the numbers are even higher. Injection drug use accounts for 51.3% of all AIDS cases among Aboriginal women and 17.6% of the cases among men.

Aboriginal IDUs are at great risk of HIV infection due to poverty, unstable housing, frequent incarceration, insufficient use of condoms, high rates of sexually transmitted disease (STD) and frequent sharing of needles. Given that the lifestyle of Aboriginal IDUs is characterized by movement to and from the street, prisons and Reserves (where they may have sex or share needles with other Aboriginal people), the

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[1] Canadian Public Health Association, "AIDS Program," Background Article #3, March 1997.
[2] *Ibid*
[3] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "Risk Behaviours Among Injection Drug Users in Canada," *HIV/AIDS Epi Update*, November 1997.
[4] Canadian Public Health Association, *op cit*.
[5] The National AIDS Task Force, *HIV, AIDS and Injection Drug Use: National Action Plan* (Ottawa: 1997): 7. (hereafter *National Action Plan*)

spread of HIV into other segments of the Aboriginal community is predictable. As one group of experts has argued, HIV infection by injection drug use shows "...little respect for geographical boundaries" and new cases are occurring in rural areas, prisons and Reserves.[6]

At present there is no cure for AIDS, but HIV infection can be easily prevented. Drug users can sterilize their needles with bleach or acquire new needles through needle exchange programs. A condom will reduce the risk of HIV infection during sex. Drug users who choose to quit using drugs can be assisted by medical assistance such as methadone maintenance programs which help addicts "...feel normal" while they attempt to establish a new lifestyle.[7] Injection drugs users can also be encouraged to switch to other forms of drug use (i.e. marijuana) which cause less harm to their health.

There are many barriers preventing IDUs from accessing health care services and information for reducing the harm caused by injection drug use. First, since injection drugs (i.e. heroin and cocaine) are illegal in Canada, groups such as prison officials do not wish to appear to be 'soft' on drugs. Moreover, the stigma of criminality discourages others from helping IDUs. The stigma of injection drug use and street life creates social barriers for IDUs when they attempt to access social and health services. For Aboriginal IDUs, the stigma of race further complicates their comfort when accessing these services.

The issue is so serious that in 1994 a *National Task Force on HIV/AIDS and Injection Drug Use* was formed to make recommendations for dealing with this "public health crisis." The *Task Force's* final report, *HIV, AIDS and Injection Drug Use: A National Action Plan* (1997) identified Aboriginal people and women as a particular focus of concern and called for immediate action by government, health officials, and all communities. The *National Action Plan* recommends a Harm Reduction approach to the issue of HIV and IDU. In this document, the recommendations and philosophy of the *National Action Plan* are embraced by the Canadian Aboriginal AIDS Network (CAAN).

CAAN is a national coalition of Aboriginal people and organizations which provides leadership, support and advocacy for Aboriginal people living with or affected by HIV/AIDS, regardless of where they reside.

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[6] *National Action Plan*: 7.
[7] Canadian Public Health Association, "AIDS Program," Background Article #3, March 1997.

1.2 The Goal

This report is Phase I of a project intended to help Community Health Representatives (CHRs) and other Aboriginal health programmers develop an appropriate response to the issue of HIV and injection drug use which will address the situation and meet the needs of their community.

Phase I of the project involves: exploring the issue of IDU and HIV by developing a social and economic profile of Aboriginal IDUs; explaining their needs and barriers to existing services; explaining the issues within prisons and the link to the overall concerns; and explaining to all the literature on Harm Reduction. It is hoped that this information will help communicate the issues and problems of HIV and Aboriginal IDU. Phase I concludes with the example of two Saskatchewan Reserves where anonymous HIV and STD testing clinics have been developed. In one of these communities a needle exchange program has been approved of by Chief and Council and funded by Medical Services Branch, Health Canada.

Phase II of the project will explain the sources of funding available for Harm Reduction programs; how links may be established with existing Aboriginal and health services; and the mechanics of needle exchange and other harm reduction programs.

The goal is for CHRs and other Aboriginal health programmers to provide Aboriginal IDUs with the information and services which they need to make informed decisions about reducing the harm caused by injection drug use. The focus is on practical solutions to the issue of HIV and injection drug use. CAAN recommends that communities develop Harm Reduction programs which meet their local needs.

The Harm Reduction model takes a value-neutral approach to drug use. It approaches injection drug use and drug users in a non-judgmental manner and treats the problem of HIV, rather than the issue of drug use, as the problem to overcome. Abstinence from drugs is not the goal of the Harm Reduction model. The goal is to empower IDUs to make informed decisions about reducing the harm associated with injection drug use. The cornerstones of the Harm Reduction model are condom distribution, needle exchange, methadone maintenance treatment and counseling. This report will assist you in developing these programs.

1.3 Desired Result

The desired results of this project are:

1. to reduce the transmission of HIV infection among Aboriginal IDUs
2. to reduce the potential for an HIV epidemic in the Aboriginal community
3. to increase the knowledge base of Aboriginal IDUs about risk behaviours
4. to encourage behavioural changes among Aboriginal IDUs (i.e. using condoms, not sharing needles).
5. to better protect Aboriginal IDUs throughout their three communities (the streets, prison and Reserves).

1.4 Costs

It should be pointed out that the cost of providing needle exchanges and condoms is substantially lower than the human and economic costs of treating a person once they have been infected with HIV. Experts estimate that the medical costs for treating one HIV+ individual is $100,000.[8] A Hamilton, Ontario, study found that a needle exchange program in that city could prevent at least 24 cases of HIV infection over five years and save the healthcare system $1.3 million.[9] In light of these estimates, Harm Reduction is clearly a sensible public policy that will, most importantly, reduce the number of lives affected by HIV.

For health, humanitarian and economic reasons, the Government of Canada has legalized needle exchange programs while Health Canada promotes Harm Reduction. The *National Action Plan* urges communities to become involved in Harm Reduction programs. Government funding is available to develop NEPs, condom distribution and methadone maintenance treatment for addicts. More specifics about government and other sources of funding will be provided in Phase II of this project.

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[8] Canadian Public Health Association, "AIDS Program", Background Article #3, March 1997; *National Action Plan*: 9

[9] Gold, M., A. Gafni, P. Nelligan, P Milson, "Needle exchange programs: an economic evaluation of a local experience", *Can Med Assoc J* 157.3 (August 1997): 255-262.

1.5 Report Philosophy

- This report is community-based. The report is framed, guided and owned by Aboriginal communities. Aboriginal IDUs and Aboriginal people living with HIV/AIDS have helped define this report and its questions. These people will also participate in its implementation.
- This report respects all individuals.
- This report does not take a moralistic stance toward drug use.
- This report is intended to develop reliable data which will allow the Aboriginal community to make informed decisions and recommendations.
- This report is built on equality and respect.

1.6 Report Structure

This report (Phase I) has 3 main components. The first part of this report reviews the issue of HIV and Aboriginal IDU. The second part of the study constructs a social, economic and behavioural profile of Aboriginal IDUs from the survey responses of 126 Aboriginal IDUs, and comparing this data to studies of other IDU communities. The third part of the study explains the barriers to existing services, and explains the important components of a Harm Reduction model.

1.7 Recommendations

- The issue of HIV and Aboriginal IDU is serious and is clearly outlined in the data and literature. The Aboriginal IDUs surveyed indicate that a Harm Reduction program will encourage behavioural change and be effective in preventing the spread of HIV. It is recommended that all Aboriginal communities implement a Harm Reduction program.

- CAAN acknowledges Correctional Services Canada's (CSC) recent efforts to develop a 5 year plan on Aboriginal HIV issues, which is Aboriginal-driven and based on the Harm Reduction model. CAAN urges the CSC to continue to work towards the

implementation of the Expert Committee on AIDS and Prisons (ECAP) recommendations.

- CAAN recommends that the national standards for Aboriginal HIV issues set in federal correction centers be observed by provincial prisons, youth centers, remand centers and other detention centers.

- It is recommended that the four main components of an Aboriginal community Harm Reduction program be: condom distribution; needle exchange; methadone maintenance treatment; and the support of the first three programs by counseling and other health services.

- It is critical that each Aboriginal community have ownership of the project programming.

- It is highly recommended that abstinence not be the focus of these programs.

- Culture is important and should be part of the Harm Reduction program. Its role needs to be determined at the local level.

- Where necessary, it is recommended that the issues of confidentiality be overcome by the use of outside nurses and/or off-site record keeping.

- At the community level the program must be non-judgmental, pragmatic and flexible.

- The program must recognize the IDUs' ability to make their own informed decisions.

- Workers and speakers who have been through street life and IDU will be important in the promotion and development of the program in each community

- Aboriginal leadership must lobby for improvements in the socio-economic situation of Aboriginal IDUs to reduce their risk of HIV infection due to poverty and unstable housing.

- It is recommended that a follow-up report (Phase II) explain the specific mechanics to implementing a community Harm Reduction program (i.e. where to access information and how to develop links between Reserves and health service providers).

- It is recommended that Phase II provide specifics on the mechanics of needle exchange and methadone maintenance programs, e.g. how to prescribe, and where to obtain funding for Needle Exchange Programs (NEP).

- It is recommended that Phase II carefully consider more methods of overcoming the barriers formed by the issue of confidentiality.

- It is recommended that Phase II consider the issues and needs of IDUs who are living with HIV/AIDS (PHAs). Information on care and treatment for IDU PHAs should be clarified. Concerns about Tuberculosis, piercing and sweats should be explored.

- It is recommend that the issue of Hepatitis C infection be further explained in Phase II.

2.0 HIV/AIDS and Aboriginal Peoples

2.0 HIV/AIDS and Aboriginal People

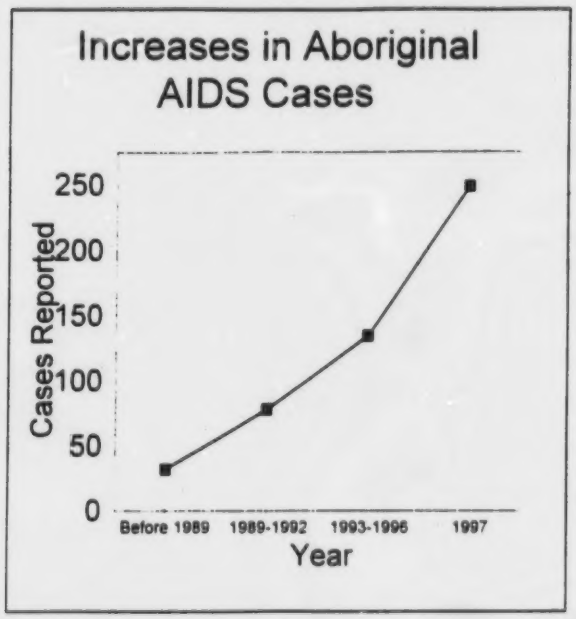
2.1 What is HIV and AIDS?

The HIV (Human Immunodeficiency Virus) is the virus believed to cause AIDS. HIV is contained within body fluids, notably blood, semen, and breast milk and can only be spread from an infected individual to another through an exchange of body fluids, typically through sexual intercourse, blood transfusions, or the sharing of needles during injection drug use or tattooing. HIV/AIDS can not be spread by casual contact.

People infected with HIV can often live for 3 to 15 years before the virus causes a break down in their immune system and they begin to display symptoms of AIDS (Acquired Immune Deficiency Syndrome). Prior to the onset of what is often called "full blown AIDS," people living with HIV will intermittently suffer from opportunistic infections due to their suppressed immune systems. These opportunistic infections can range from simple skin infections to serious afflictions of the central nervous system. A cure for AIDS has not been developed, but multiple drug therapy programs (protease inhibitors) have made significant inroads into the management of the disease. Due to these drugs, many people living with HIV have long periods of recovery from opportunistic infections and can return to normal everyday life. Yet some may suffer crippling side effects, and the long term effects of the drugs have never been tested. For the IDU, the issues are even more complicated. They often have trouble accessing the drug therapies and greater difficulty complying with the strict regimens.

Once "full blown" AIDS develops, a person will often suffer from a variety of physical and mental afflictions, including: weakness and fatigue, respiratory problems, skin problems, oral infections, neurological problems, anxiety, and depression. After their immune system has collapsed, people with AIDS may die from an illness such as pneumonia.

2.2 HIV/AIDS in the Aboriginal Community



Source: Health Canada HIV/AIDS Epi Update (November 1997)

Initially, HIV infection rates in the Aboriginal community appeared much lower than those among the national population. This has changed. The number of Aboriginal AIDS cases has increased eightfold since 1989. Health Canada estimates that there are 305 Aboriginal AIDS cases in Canada or 30.5 Aboriginal AIDS cases for every 100,000 Aboriginal people.[10] However, this number which includes only the cases of AIDS (and not HIV), is widely recognized to be under-estimated in the case of Aboriginal peoples. 40% of the cases of HIV reported to Health Canada do not specify the individual's ethnicity. In 1995, the Ontario Aboriginal HIV/AIDS Steering Committee compiled the private case loads of Aboriginal AIDS organizations across Canada and estimated that there were between 1000 and 1500 Aboriginal people living with HIV/AIDS at that time. In Saskatchewan, Aboriginal people made up 78% of the HIV cases detected in an anonymous HIV testing program.[11]

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[10] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "HIV/AIDS Epidemiology Among Aboriginal People in Canada," *HIV/AIDS Epi Update*, November 1997.

[11] *Ibid.*

2.3 How & Why HIV is Spreading in the Aboriginal Population

HIV is spreading in the Aboriginal community in a different manner from the non-Native community. For example, women compose 7% of all AIDS cases in the general Canadian community, while in the Aboriginal community, women make up 15.1% of AIDS cases. Aboriginal people are also being infected with HIV at a younger age than non-Natives.[12] Families and mothers are also being infected. Aboriginal women represent 41% of those under care at a BC clinic that cares for pregnant HIV+ women.[13]

Mode of Transmission of HIV/AIDS in the Aboriginal Community

Mode of transmission	Female	Male
Men who have sex with (MSM)	0	60%
Injection Drug Use (IDU)	51.3%	17.6%
MSM/IDU	0	13.8%
heterosexual contact	30.8%	4.3%
recipient of blood/clotting factor	10.3%	1.0%
perinatal transmission	5.1%	1.0%

Source: Health Canada *HIV/AIDS Epi Update*

This data presents a very problematic picture of how HIV is spreading in the Aboriginal community. Health Canada has broken down its list of Aboriginal AIDS cases to find that injection drug use accounts for 17.6% of the AIDS cases among Native men and 51.3% of those among Native women. Injection drug use accounts for only 3.5% of the AIDS cases among men and 18.1% among women in the non-Native community.[14] Alberta and British Columbia studies indicate that injection drug use made up 60% and 75% of all new Aboriginal HIV cases, respectively.[15] Despite representing less than 2% of the Canadian population, Aboriginal people represent between 25% and 75% of the people using various urban needle exchange programs and counseling/referral services.[16]

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[12] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "HIV/AIDS Epidemiology Among Aboriginal People in Canada," *HIV/AIDS Epi Update*, November 1997.
[13] *Ibid.*
[14] *Ibid.*
[15] *Ibid.*
[16] *Ibid.*

The predominant mode of HIV infection in the Native and non-Native community is sex between men, yet heterosexual sex is a significant method of HIV transmission in the Aboriginal community. The Alberta and British Columbia case studies found heterosexual contact accounted for 13% and 12.5% respectively, of new HIV infections among Aboriginal people. Heterosexual contact accounts for 30% of the reported AIDS cases among Native women.

Health Canada confirms that HIV infection through injection drug use and heterosexual sex is more of a problem in the Native community than the non-Native community and that, "...the HIV epidemic among Aboriginal people shows no signs of abating."[17] The need for a response to reduce the harm of injection drug use and HIV in the Aboriginal community is clear.

[17] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "HIV/AIDS Epidemiology Among Aboriginal People in Canada," *HIV/AIDS Epi Update*, November 1997.

3.0 The Research Methodology

3.0 The Research Methodology

To begin to understand and communicate about the behaviours and issues affecting Aboriginal IDUs, CAAN decided that it was necessary to conduct a survey among Aboriginal IDUs across Canada.

3.1 Methodology

In order to know what is happening on the streets, questions must be asked of people who live on the streets. However, injection drug users are among the most inaccessible groups in society and Aboriginal IDUs are even more difficult to access. A random probability survey of Aboriginal IDUs across Canada is difficult because the exact contours of the Aboriginal IDU population are unknown and hence the creation of a reflective sample is problematic. Also, the costs for this type of survey are prohibitive.

For the purposes of this project, it was decided to simply develop a questionnaire and to try to reach as many Aboriginal IDUs as possible through existing service providers. The answers provided will not precisely reflect the rates or percentages of certain attributes and behaviours in the whole population; however, they will provide a picture of the range of answers and experiences of Aboriginal IDUs in Canada. When these results are compared to other studies of similar populations, certain findings can be generalized, patterns can be observed and some predictions can be made. Of course, like most studies of this nature, absolute claims cannot be made from the data alone.

Survey Sites

Study location	Service Organization	# of completed questionnaires
Toronto	Parkdale Clinic	18
Thunder Bay	The Exchange	10
Winnipeg	Street Connection	20
Saskatoon	Downtown Youth Center	20
Edmonton	Boyle St. Co-op Center	18
Vancouver	Vancouver Native Health	28
Federal prison		12
Total		126

The development of the questionnaire was overseen by a steering committee composed of members of CAAN, Health Canada and an Aboriginal outreach worker. The questionnaire was piloted in Vancouver with ten Aboriginal IDUs. Revisions were based on feedback from this trial group. The target group is all Aboriginal IDUs. It was

decided to reach Aboriginal IDUs through existing service agencies and in prisons. The survey was advertised by means of posters, flyers and word of mouth from the eight service providers that offered assistance. Contacts were also developed with Correctional Services Canada. Compensation of $20.00 was offered to each respondent.

It was decided to conduct the surveys in focus groups of 10 individuals at each service agency. In the focus group setting, participants were informed about the purpose of the study and assured confidentiality. The CAAN researcher was concerned that some of the survey questions might distress some of the respondents and felt that a focus group format would allow for the presence of a facilitator who would be available for a post-completion discussion with the respondents in order to deal with any concerns or issues raised. The facilitator was often a staff person from the host organization.

3.2 The Objectives of the Survey

The objectives of the survey are to collect data for the construction of a profile of the social and economic situation of Aboriginal IDUs across Canada, to create an understanding of the behaviours which place IDUs at risk of HIV infection, and to determine the existing barriers to reducing the harm caused by injection drug use. These objectives may also be described as:

1) to determine a profile of the Aboriginal IDU population across Canada (in urban and prison settings) in terms of sex, age, residence, mobility, sexuality and socio-economic profile;
2) to foster a better understanding of Aboriginal IDU drug preferences and injection drug use practices;
3) to educate toward a more informed understanding of what IDUs know about HIV and of their injection drug use and sexual risk behaviours;
4) to survey Aboriginal IDUs knowledge of existing community services and the barriers they face in accessing those services;
5) to gauge what Aboriginal IDUs themselves would see as ideal services; verify the importance and/or relevance of Aboriginal culture when providing services.

3.3 The Survey -- Methodological Problems

The research questionnaire had some problems, many of which were due to inexperience and insufficient critiquing of the research instrument. Problems with the questionnaire may be listed as follows. The questionnaire was too long. Some questions were unclear or ambiguous and this data had to be rejected. Some important questions were not asked, and some insignificant questions were asked. The closed-ended questions were some times too limited. An improved critique and pilot study of the questionnaire could have caught these shortcomings. The implications of these problems is not always clear. In comparing the data to other studies, we have reasons to believe that theses weaknesses do not greatly affect the nature of the data in key areas.

3.4 Returns and Data Analysis

In the end, surveys were conducted at 6 urban service centers across Canada and 2 federal prisons. 126 Aboriginal IDUs responded to the questionnaire. 12 of whom are inmates.

The initial research, development, and execution of the questionnaire was conducted by CAAN and the steering committee. The data analysis and write-up was done by the consulting firm *Watershed Writing and Research*.

4.0 The Survey

4.0 The Survey

4.1 The Sample

In total, 126 people completed the questionnaire. All respondents share a history of regular injection drug use. The majority inject daily. However, 12 respondents have stopped using injection drugs and 11 were not using at the time of the survey. It is hoped that the survey answers provided by these people will tell us about the lifestyle, beliefs, issues and personal needs of Aboriginal IDUs.

Characteristics of this Sample of Aboriginal IDUs

	number in the sample	% of the sample
Sex		
Male	62	49%
Female	63	50%
Transgender	1	1%
Sexual Orientation		
Straight	110	87%
Lesbian	2	2%
Gay	2	2%
Bisexual	8	6%
Undisclosed	4	3%
Age		
15-19	17	14%
20-24	14	11%
25-29	21	17%
30-34	26	21%
35-39	20	16%
40-44	19	15%
45-49	5	4%
50-54	2	2%
55-60	1	1%
undisclosed	1	1%
Education		
Grade 9 and less	38	30%
Grade 10	33	26%
Grade 11 to 13	32	25%
Some college	3	2%
Some university	7	6%
undisclosed	13	10%

The respondents include 62 males, 63 females and 1 transgender IDU. While it is striking that a large number of women completed the questionnaire, this does not necessarily mean that half the Aboriginal IDU population in Canada is female.

The respondents do not have much formal schooling. While 17% of the overall Native population in Canada above the age of 15 report no formal schooling or less than Grade 9, 30% of the respondents are within this category.[18] The majority did not attend school beyond Grade 10. Similarly, 34% of the general Native population over the age of 15 report having some post-secondary education, but only 8% of our respondents have attended college or university courses. [19]

The twenty (20) youngest respondents (aged 15 to 20 years) were accessed through a needle exchange program which only serves that age group. Despite this large number of youth, the respondents are predominantly between the age of 25 and 40 and appear to be older

[18] Statistics Canada, "Schooling, Work and Related Activities, Income, Expenses, and Mobility," ABS, cat no. 89-534.
[19] *Ibid.*

than the average non-Native IDU who is generally in his/her 20s.[20] Eighty-three percent (83%) of the respondents began injecting drugs before they were 24 years of age and 60% first injected before they were 20 years old.

The respondents are very poor. Social Assistance is the source of income for 74% of these Aboriginal IDUs. This is 2.6 times the average (29%) for Aboriginal people in Canada.[21] Extra-legal sources of income are a part of the lifestyle of Aboriginal IDUs -- generally to cover the cost of drugs. As a result of this socio-economic situation, 87% of the sample have been incarcerated, often for drug-related crimes. Sex trade work is a source of income for 71% of the female respondents.

Housing and Economics

	number in the sample	% cent of the sample
Source of Income		
Welfare	93	74%
Job	12	10%
Parents, family	3	2%
Drugs, theft	12	10%
Undisclosed	6	5%
Sex trade		
Women	45	71%
Men	3	5%
Transgender	1	100%
Housing		
House	29	23%
Apartment	35	28%
Shared house	11	9%
Rooming house	19	15%
Shelter	4	3%
Streets	11	9%
Hotel	5	4%
Prison	12	10%

The respondents' housing is very unstable. Not including those in prison, 44% of the sample group live on the street, in boarding houses, hotels or shelters. Over half of the Aboriginal IDUs who report stable housing are residents of Saskatchewan, where housing is less expensive and more accessible. As shown below, unstable housing places IDUs at a greater risk of contracting HIV.

4.2 Social Issues

The *Royal Commission on Aboriginal People* (1996) has found that because of a history of unequal equal access to resources, residential schooling, racism and unequal access to resources, Aboriginal people are over-represented among Canadians who are unemployed, abuse alcohol and drugs and commit suicide. In residential schools, sexual

[20] Remis, Robert, et. al. *The HIV Epidemic among Injection Drug Users in Ontario: The Situation in 1997*, prepared for the AIDS Bureau, Ontario Ministry of Health.
[21] Statistics Canada, "Schooling, Work and Related Activities, Income, Expenses, and Mobility," ABS, cat no. 89-534.

and physical abuse was sometimes rampant and several generations of parenting skills were lost, while generations were taught to internalize shame for being Native. As a result of residential schooling, a system of abuse and shame has been set in motion in First Nations' communities.

The responses of the 126 Aboriginal IDUs suggest that they may have ended up on the streets or turned to injection drugs because of this legacy of abuse that has been set in motion. Alcohol was prominent in the majority (70%) of all childhood homes and over 64% of the respondents were raised in homes which were violent. The majority of female respondents report surviving sexual assault, sexual abuse and physical abuse. Incest was experienced by as many as 44% of the female respondents. Between 18% and 24% of the men report sexual assault and sexual abuse, respectively. Almost half the male respondents have experienced physical abuse. Overall, 49% of respondents spent some time in a foster home. Fifty percent (50%) of the respondents have attempted suicide.

Social Issues for the Sample

	Number in the sample	% of the sample or subgroup
Raised in a:		
Foster home	62	49%
History of Abuse		
Women		
Sexual assault	34	54%
Sexual abuse	35	56%
Incest	28	44%
Physical abuse	45	71%
Men		
Sexual assault	11	18%
Sexual abuse	15	24%
Incest	9	15%
Physical abuse	30	48%
Domestic history		
Home with violence	81	64%
Home with alcohol	90	72%

In sum, the respondents' problems did not begin on the street; but rather, some of their problems began through a legacy of abuse set in motion some time ago.

4.3 Knowledge of HIV and Risk Behaviour

It is apparent that the message about HIV is effectively reaching people on the street as the respondents have an excellent knowledge of HIV. Of all respondents, 94% knew about HIV/AIDS and demonstrated a consistent and accurate knowledge of its various modes of transmission. Further to this, 89% of the respondents have been tested for HIV and know

Knowledge Issues

	number in the sample	% of the sample
Know about HIV/AIDS	119	94%
Tested for HIV	112	89%

their HIV status. In part, this excellent personal and general knowledge of HIV is representative of the fact that the majority of the sample were accessed through NEPs or AIDS service organizations where HIV education and testing are part of the service programming.

The answers to a series of questions in the survey indicate that the sample do not want to contract HIV and do not accept HIV infection as an inevitable part of their lifestyle. Most members indicate that they would be suicidal, depressed, or "freak-out" if they tested HIV+. High levels of respondents felt "good" about determining their HIV status. When tests proved negative, they used this information to protect themselves from the risk of infection. When asked how they would respond to a positive result, many predicted strong negative reactions, ranging from shock to possible suicide.

In this study, a picture is emerging of a group of Aboriginal people who have excellent knowledge of HIV and wish to protect themselves and others from HIV infection. It is our responsibility to assist them with behavioural changes by making condom distribution and needle exchange programs available. For those interested in quitting injection drug use, it is important to make methadone maintenance, counseling and support services available. Moreover, it is our responsibility to see that these services are available wherever these people travel, including Reserves and prisons.

How would you react to a positive test result?
Feel bad and want to end my life.
I'd flip out if I got a positive test result
I've got no idea how the hell I'd react. Seen close friends go crazy when they tested positive.
I am sure it would come as a shock
I feel I would kill myself

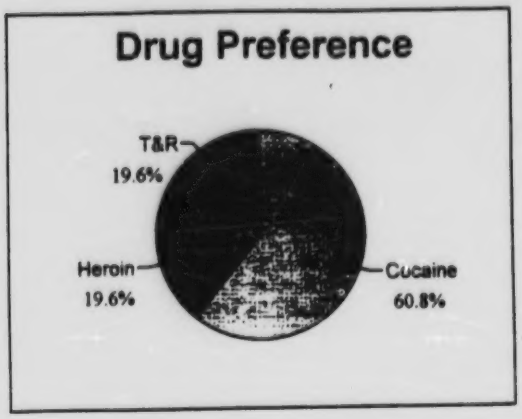
5.0 Aboriginal Drug Use Behaviour & Potential Harm

5.0 Aboriginal Injection Drug Use Behaviour & Potential Harm

A series of questions in the survey were designed to help us understand the lifestyle and drug injection behaviour of Aboriginal IDUs, so that communities are better able to facilitate the development of an Aboriginal Harm Reduction program.

5.1 The Choice of Drug: Cocaine, Heroin or Talwin/Ritalin

There three most common drugs injected by IDUs are heroin, cocaine and talwin/ritalin (T&R). In the past, heroin (an opiate derived from morphine) was the drug of choice among IDUs. However, many IDUs have switched to cocaine (an alkaloid drug made from the coca plant). In a Vancouver study, it was found that cocaine is injected by 80% of NEP attendees. In Montreal and Halifax, 70% and 52% of IDUs prefer cocaine, respectively.[22] Among our study respondents, cocaine was reported as the drug of choice by 50% of the respondents and was three times more popular than heroin or Talwin/Ritalin.



The drugs consumed vary by city. Heroin is used by half the respondents in Thunder Bay, but only 29% of the respondents in Vancouver. Talwin/Ritalin (T&R) is most popular in Saskatoon, where it is used by 35% of the respondents and in Vancouver, where 21% use it. Overall, cocaine is used by over 50% of the respondents.

The switch to cocaine among injection drug users has caused concern among health experts because cocaine addicts may require as many as 20 injections per day. This is five times more daily injections than practiced by heroin addicts. Heroin addiction requires approximately 4 injections a day. The concern follows that a switch to

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[22] *National Action Plan*: 9

cocaine creates 5 times as many opportunities for an IDU to share needles through an absence of clean needles. Also, as CAAN notes:

> "Even intravenous drug users aware of the high rates of HIV transmission through needles are sometimes unwilling or unable to clean their works. The compulsion to use is sometimes stronger than the need to protect themselves."[23]

5.2 The Risks: HIV and Hepatitis C Infection

As stated, the risk during injection drug use is that the sharing of needles may pass HIV+ blood between people sharing a needle. Hepatitis C may also be passed by sharing a needle. It is a virus which attacks the liver. Hepatitis C is a stronger virus than HIV and can not be killed by cleaning needles with bleach. In Vancouver, 90% of the IDU community is infected with Hepatitis C. The issue of Hepatitis C infection was not a focus in the questionnaire answered by the 126 Aboriginal IDUs and thus, is not extensively discussed in this document. Nevertheless, the issues of Hepatitis C infection should be considered in the rationale for Harm Reduction programs and it is recommended that it be further explored in Phase II of this project.

5.3 Injection Drug Use Behaviour

As previously stated, the respondents are generally in their 30s and most members of the sample group began using injection drugs before they reached the age of 20. Thus on average, respondents have been injecting drugs for over 10 years.

Over half the respondents inject daily, but it is unclear from the survey how many times per day people inject. It would seem likely that cocaine use necessitates as many as 20 injections per day. Twenty-nine percent (29%) of the respondents indicated that they inject weekly and a further 15% say they inject monthly. A large majority of respondents (89%) drink alcohol (generally beer) while injecting. The amount of alcohol consumed is generally described as "lots" or "all I can get."

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[23] Canadian Aboriginal AIDS Network, "AIDS & Addictions," n.d.

Injection Drug Use among the Sample		
	Number in the sample	% of the sample or subgroup
Age at first injection	Total: 126	
10-14	23	18%
15-19	53	42%
20-24	29	23%
25-29	6	5%
30-34	9	7%
35-39	1	1%
over 40	1	1%
undisclosed	4	3%
Regularity of Injection	Total: 114	
Daily	61	54%
Weekly	33	29%
Monthly	17	15%
Missing cases	3	3%
Source for Needles	Total: 126	
Buy	15	12%
NEP	71	56%
Both of the above	30	24%
Friends /other sources	3	2%
Undisclosed	7	6%
1 needle for every injection	Total: 126	
Always	67	53%
Sometimes	42	33%
Seldom	10	8%
Undisclosed	7	6%
Shared needles in the last year	Total: 126	
Yes	45	36%
No	68	54%
Missing cases	13	10%
Shared with	(multiple answers)	
Partner	32	
Friends	27	
Family	11	

Needle exchange programs comprise the respondents' primary source of needles. Only 12% indicate that they purchase needles from drug stores; a very small number (2%) rely on friends or other sources for their needles. The high rate of NEP use suggests that NEPs are successfully providing safer sources of needles for these users.

An important question is whether the members of the sample group restrict themselves to one needle per injection? Just over half report using one needle for every injection, while 41% report "seldom" or "sometimes" using one needle for every injection.

Another important question is how many people share their needles with other IDUs. It is the process of sharing that puts people at risk of HIV infection. It is this behaviour which needle exchange programs seek to change. In our study, 36% of the Aboriginal IDUs report sharing needles within the last year. This incidence of needle sharing is lower than studies in Vancouver, Ottawa and Montreal, which found that 40-44% of NEP users had shared needles within the last 6 months.[24] Most respondents who shared needles indicated doing so only with their partners.

[24] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "Risk Behaviours Among Injection Drug Users in Canada," *HIV/AIDS Epi Update*, November 1997; Strathdee, Steffanie, et. al. "Needle exchange is not enough: lessons from the Vancouver injecting drug use study", *AIDS* 11 (1997):F59-F65..

It is important to know whether IDUs are cleaning their needles with bleach before sharing. Needles may be cleaned and safely re-used if a process of cleaning with bleach is followed. It was found that 22% of the 40% of NEP attendees that share needles in Vancouver, consistently clean their needles with bleach.[25] Among our respondents, a much higher number (80% of those who share needles), report cleaning their needles every time. At the same time it is clear that 20% of the IDUs that share needles do not clean their injection equipment every time (overall, this is 9 people in a sample of 126 or 7% of the total sample). These are the people about whom we are the most concerned.

In summary, a high number of Aboriginal IDUs have knowledge about HIV and use NEPs in cities. Concern exists for the 36% who share needles with partners, for the 41% who do not restrict themselves to one needle per injection and for the 7% of the respondents who share and do not clean their needles.

5.4 Sexual Risk Behaviour of IDUs

Sharing needles is not the only means by which HIV is spreading in the injection drug use community. Sex among members of the IDU community is another method for the spread of HIV. Sex with non-users has been a means for introducing HIV into the IDU community. Now sex with non-users is a means for spreading HIV to other communities such as on Reserves and into prison populations. A simple condom can reduce the risk of HIV infection between sexual partners.

A study conducted among NEP attendees in Ottawa and the province of Québec found that 54.9% of women with multiple male partners "never or only sometimes" use condoms. Among men with multiple female partners, 56.7% infrequently use condoms. For these men and women the infrequent use of condoms increases to 73.6% (for men) and 79.6% (for women) with regular partners.[26] In our survey 42% of women with non-regular male partners report "never or only sometimes" using condoms while 48% of men

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[25] Strathdee, Steffanie, et. al. "Needle exchange is not enough: lessons from the Vancouver injecting drug use study", *AIDS* 11 (1997):F59-F65.

[26] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "Risk Behaviours Among Injection Drug Users in Canada," *HIV/AIDS Epi Update*, November 1997.

with non-regular female partners report "never or only sometimes" using condoms. Finally, among men and women with regular partners 52% report never or only sometimes using condoms.

Both the Ottawa and the Québec studies, found that 75% of men who have sex with men report never or seldom using condoms. The number decreases to 72.5% for men with regular male partners.[27] In our survey the three men who indicated that they are gay or bisexual report never or seldom using condoms (two men have regular partners). The one transgendered member of the sample group reports a constant use of condoms.

As noted, 71% of the Aboriginal women in our survey are engaged in the sex trade in order to obtain money and/or drugs. These women are at a significant risk of contracting HIV. Indeed 27% report sometimes or never using condoms. This number is lower than that found in the Ottawa-Québec study where 35.5% of women did not use condoms while trading sex for money or drugs. The two men in our survey who report commercial sex with men also (100%) report irregular use of condoms. The Ottawa-Québec study found irregular condom use among 63% of male sex trade workers who have sex with men.[28]

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[27] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "Risk Behaviours Among Injection Drug Users in Canada," *HIV/AIDS Epi Update*, November 1997.
[28] *Ibid.*

6.0 Canadian Prisons, The Issue of HIV/AIDS and Aboriginal People

6.0 Canadian Prisons, the Issue of HIV/AIDS, & Aboriginal people

6.1 Introduction to the Issues

The incarceration rate of Aboriginal people in Canada is high. The incidence of HIV in Canadian prisons is also high as a result of injection drug use, sex, and tattooing in jails. A series of major reports indicate that federal and provincial prisons have a moral, ethical and legal responsibility to help inmates protect themselves from HIV infection by making condoms and needles readily available.[29] IDU inmates have been unable to protect themselves against HIV infection because prison officials are reluctant to allow prisoner access to clean needles. It has often been said that "*...a three-month sentence should not become a death sentence*". The experts have clearly stated that prisoners have a right to protect themselves in jail.

The objective for this section of the document is to outline the issues associated with incarceration, Aboriginal injection drug use and HIV/AIDS and to show how these issues affect the individual IDU, and potentially, our whole community. This section integrates a series of reports and studies with the answers provided by the 126 Aboriginal IDUs about sex and drug use in prison. Twelve of these respondents are presently serving sentences in Canadian correctional centers and answered a modified questionnaire. The questionnaire was modified in part to meet codes of ethical conduct for research in prisons. For example, inmates were not asked about the nature of their crimes. Some new questions were specifically asked of the Aboriginal inmates in order to improve our understanding of certain prison issues.

6.2 Prisons and HIV/AIDS.

HIV/AIDS and Hepatitis C have become "emergency" issues in Canadian prisons.[30] Between April of 1994 and March of 1996, the number of known cases of

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[29] *HIV/AIDS in Prisons: Final Report, Joint Project on Legal and Ethical Issues* (Montreal: Canadian HIV/AIDS Legal Network, Canadian AIDS Society, 1996).
[30] *National Action Plan*: 8.

HIV/AIDS in federal prisons rose by 46% (going from 109 to 159 cases)[31]. Current numbers indicate that over 1% of all federal inmates are known to be living with HIV/AIDS.[32] The Canadian AIDS Society (CAS) reports that in some Québec federal prisons over 5% of inmates are known to be HIV+.[33] In terms of Hepatitis C, three studies have found rates as high as of 28 to 40% in federal prisons.[34] Studies conducted in British Columbia, Ontario and Québec indicate that the rate of HIV/AIDS is the same in provincial jails as it is federal institutions and that sero-prevelance rates ranging between 1 and 7.7%.[35] Most significantly, the rate of HIV sero-prevalence is thus ten times higher in prisons than it is in the general population.

6.3 Aboriginal People in Prison

Aboriginal people compose less than 2% of the Canadian population, but represent an average of 14% of the people in federal prisons. Some provincial prisons have Aboriginal incarceration rates of up to 75%.[36] In our sample of 126 Aboriginal IDUs, 84% of the women and 90% of the men have spent time in prison. The average among all respondents is 87%. Conversely, only 13% of the respondents have not been in jail. The crimes committed by the respondents are largely drug-related (see section 6.4). When asked about the length of their longest sentence, a large number of respondents (44%) indicate that their longest sentence was between one day and three months. Although this was not

Incarceration Rate Among Respondents		
	Number in the Sample	% of the sample or subgroup
Been Incarcerated		
Yes	109	87%
No	17	13%
Longest Sentence (approx.):		
Less than 1 week	14	12%
1 to 2 weeks	16	13%
1 to 3 months	23	19%
6 to 11 months	13	11%
1 year	7	6%
1> year to <3 years	17	14%
3 years	9	8%
3> to 6 years	11	9%
7 to 20 years	6	5%
Life	3	3%

[31] *HIV/AIDS in Prisons: Final Report. Joint Project on Legal and Ethical Issues* (Montreal: Canadian HIV/AIDS Legal Network. Canadian AIDS Society, 1996): 31
[32] *Ibid.*:32
[33] *HIV/AIDS in Prisons: Final Report. Joint Project on Legal and Ethical Issues* (Montreal: Canadian HIV/AIDS Legal Network. Canadian AIDS Society, 1996): 32.
[34] *Ibid.*: 31.
[35] *Ibid*: 32.
[36] personal communication, April 1998

specifically addressed in the questionnaire, clearly there are incidences of repeated incarceration among the respondents. Thus, a large majority of this group of Aboriginal IDUs are frequently moving through prisons for short periods of time due to drug and street related crimes. As will be discussed below, these people cannot protect themselves while in jail.

6.4 Drug Related Crime

As noted earlier (section 4.2), many of the respondents may have ended up on the streets due to abusive situations in their homes. Drug use is one means of coping with abuse, social dislocation and poverty. Given that IDUs are among the poorest people in the country, illegal activities are often necessary to assist with the cost of drugs. These illegal activities generally involve theft from friends, family, and employers; prostitution; break and enter; and other crimes. It is estimated that in the United States 50% of all urban property crimes are related to crack cocaine.[37] Our survey respondents are very poor and among the most marginalized people in Canada. Social assistance is the source of income for 74% of respondents, of whom, only 33% are satisfied with this income. Sex trade work forms part of the income for 71% of the women surveyed.

As can be expected, the offenses committed by the respondents who have been to jail are related to drugs. The most frequent forms of crime are theft, break and enter, assault, drug trafficking, drug possession and prostitution.

[37] William J. Bailey, "Factline of Cocaine," Indiana Prevention Resource Center at Indiana University, world wide web (www).

6.5 Injection Drug Use and Sex in Prisons

As the *National Action Plan* clearly states, sex and injection drugs are a "fact of life" in prison.[38] Recent studies provide evidence of the extent of injection drug use and sex in prisons. A study in a Montreal medium security prison found that 73.3% of all men and 15% of all women used some form of drugs while incarcerated and that injection drugs were used by 6.2% and 1.5% of men and women, respectively. Other studies have found different rates of injection drug use. A study in Québec City found that only 2% of inmates reported injection drug use; while inmates in a federal prison in New Brunswick reported a rate of 7.5%. A survey conducted by Correctional Services Canada (CSC) found that 11% of inmates reported injection drug use.[39] All these studies found that inmates generally share their needles.

Drug Use and Sex in Prison

	# in the subgroup	% of the sub-group
Use when Incarcerated (out of 109)		
Yes	55	50.5%
No	54	49.5%
Use among those currently Incarcerated (out of 12)		
Use while incarcerated	11/12	96%
Use of injection drugs	11/11	100%
Shared needles	8/11	73%
Sex while Incarcerated (out of 12)		
Yes	1/12	8%
No	11/12	92%

Our survey of 126 Aboriginal IDUs found some very different and striking numbers. The respondents were asked, "Did you use while incarcerated?" and "If yes, what?" Seventy-one (71%) of men and 28% of women report some form of drug use when they were incarcerated (i.e. marijuana, pills, cocaine, etc.). Although a specific question about injection drug use was not asked, when the list of all drugs used is broken down it is found that 43% of all men used the injection drugs heroin and T&R while incarcerated. Cocaine can be taken in a variety of ways. If cocaine was injected in all cases where use was reported, the rate of injection drug use can climb as high as 54% of all men while incarcerated. In any event, the rate of injection drug use by Aboriginal men when incarcerated is between 43 and 54%. Meanwhile, marijuana and the use of pills is

[38] *National Action Plan*: 8.

more frequently reported among Aboriginal female inmates, only 8% of whom reported use of heroin or T&R when in jail.

Our survey numbers regarding injection drug use among men and women are much higher than the rates cited in the above studies. One probable reason that the rate of injection drug use during incarceration is higher among our respondents is their familiarity with, or addiction to, injection drugs prior to incarceration.

The 12 Aboriginal respondents presently incarcerated were asked some specific questions about drug use, 11 of whom (96%) report the current use of injection drugs in jail and 8 of whom (73%) share their needles and works. When asked how widely a needle is shared, the majority (63%) answered that a single needle may be shared by 1 to 5 people and a quarter (25%) believe that a needle may be shared by more than 16 people. Seven of the 8 respondents (88%) who share needles report sterilizing the needle with bleach prior to use.

It should be noted that while 36% of the respondents share needles on the streets, 73% share needles in jail. Clearly, the sharing of needles is not a normal behaviour but rather one brought on by the conditions of prison.

The findings of studies on sexual conduct in prison are quite consistent. The Montreal medium security prison study found that 6.1% of men and 6.8% of women report having sex in prison. Similarly, the CSC survey found that 6% of inmates report sex in prison. The New Brunswick study found a rate of 9%. Condom use was reported by only 33% of inmates in the CSC survey.[40]

In our study, only 1 of the 12 respondents (8%) reports having sexual intercourse in prison. This person practices safe sex. It is possible that homophobia prevents some men from disclosing their sexual activity while in prison and that the rate may be higher. While our sample of incarcerated men is too small a one on which to base predictions and possibly skewed by an unwillingness to disclose one's sexual activity, this rate is consistent with the rates reported in the Montreal, CSC and New Brunswick studies cited above (where the same biases might exist).

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[39] *HIV/AIDS in Prisons: Final Report, Joint Project on Legal and Ethical Issues (Montreal: Canadian HIV/AIDS Legal Network, Canadian AIDS Society, 1996): 38.*

[40] *HIV/AIDS in Prisons: Final Report, op.cit.*: 38.

6.6 Synthesis of the Problem

Our data illustrates a serious problem. Many Aboriginal people end up on the streets due to abusive home situations, often as a result of the legacy of residential schooling. Injection drug use is one means of coping with social dislocation, but poverty often forces Aboriginal IDUs to engage in illegal activities to earn money for drugs. A vast majority of the respondents have been incarcerated and a high number of the prison sentences are short, between one day and three months. The respondents have a very high level of knowledge about risk behaviours and the modes of HIV transmission. In prison, where the prevalence of HIV is high, up to half of the respondents continue to use injection drugs and a certain number continue to have sex. The problem is that Aboriginal IDUs are at high risk of HIV infection because they have a very high likelihood of going to jail and because they have a high level of risk behaviour while in jail. After release from prison, Aboriginal IDUs return to the streets and often visit their home Reserves (see section 7). If they are HIV+ they risk infecting others through unprotected sex and needle sharing. Consequently, the high risk of HIV infection in prison puts *all* Aboriginal communities at an increased risk of an HIV epidemic.

The question which needs to be addressed is: How can Aboriginal IDUs protect themselves against HIV infection in jail?

6.7 Correctional Services Canada's Response

Correctional Services Canada has been expertly informed about the problem of HIV infection in prison: the issue of HIV infected inmates possibly infecting their communities upon their release: and the specific HIV issues of Aboriginal inmates.

In 1992, the Prisoners with HIV/AIDS Support Action Program (PASAN) released a study of the issues. Most significantly, in 1994 ECAP released a *Final Report* which contained an unequivocal argument for the prisoners' right to protect themselves against HIV infection and the Government of Canada's obligation to help inmates in this regard. ECAP called for a Harm Reduction program in federal prisons and specifically recommended that condoms, dental dams and water-based lubricants be made easily

available; that bleach kits be made available to all inmates; and that methadone maintenance programs be made available. It was ECAP's conclusion that each of these programs will reduce the harm associated with sex and injection drug use in prisons. With regard to sterile injection equipment, ECAP recommended that a pilot NEP program be undertaken in one federal prison to assess the issues. ECAP also specifically identified the unique issues of Aboriginal people and HIV in prisons and recommended that Aboriginal inmates have access to Elders and healers; that Aboriginal specific education programs be developed and delivered by Aboriginal people; that Aboriginal peer education, counseling and support programs be developed; and that CSC and Health Canada fund these programs.[41]

CSC's initial response to the ECAP *Final Report* was a reluctance to implement the Harm Reduction recommendations. In part, CSC was unwilling to appear 'soft' on drugs or appear to be sanctioning the use of illegal drugs. The CSC's preferred response to the issue of HIV infection in prisons was to clamp down on illegal drug use. This strategy is ineffective and inconsistent with the recommended Harm Reduction model which accepts that drug use is impossible to eradicate; which treats HIV infection as the real problem; and seeks to help inmates reduce the harm associated with drug use. CSC also failed to implement the ECAP recommendations for Aboriginal inmates.

In response to CSC's reluctance to implement ECAP's recommendations, the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society released a follow-up report in 1996 called *HIV/AIDS in Prisons: Final Report.* This *Final Report* criticizes the CSC for not implementing the ECAP recommendations. Once again, this report tries to outline a pragmatic response and urges CSC to implement a Harm Reduction model. The *Final Report* recommends that CSC:

> "...adopt a more pragmatic approach to drug use, acknowledging that the idea of a drug-free prison is no more realistic than the idea of a drug-free society and that, because of HIV/AIDS, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an

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[41] *HIV/AIDS In Prison: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Correctional Services Canada, 1994): 118.

important goal, but reduction of the spread of HIV and other infections is more important."[42]

In November 1995 a CSC study confirmed the emergency nature of HIV risk behaviours in prison. In 1996, CSC responded to some of the ECAP recommendations and made it a national policy that bleach kits, condoms, lubricants and dental dams be made available to all inmates. CSC did not however implement the recommendations concerning Aboriginal inmates. Very significantly, CSC has still not undertaken a pilot NEP program. In part, there is some concern among the guard's union that needles may be used as weapons, although it is pointed out that needles are already in prisons and are not reportedly used as weapons now.

In November 1996, after no response on the ECAP recommendations concerning Aboriginal inmates, the Commissioner of Corrections publicly noted the CSC's failure to respond to the specific issues of Aboriginal inmates. In a Parliamentary Committee on HIV/AIDS, the Commissioner of CSC finally "...indicated his intention that CSC develop specialized programming for Aboriginal inmates as part of a major strategy. He also indicated that he would like to see Elders as part of that process."[43]

In October 1997, at the instigation of the Manitoba Corrections' Council of Elders (MCCE), the CSC co-funded and attended a conference on "...the continuum of services for inmates with HIV when they make the transition from institution to community", sponsored by the Manitoba Aboriginal AIDS Task Force, the MCCE and Simon Fraser University. [44] In April 1998 CSC held a meeting with Aboriginal HIV/AIDS experts and Aboriginal stakeholders on prison issues for the purpose of developing a 5-year strategic plan on Aboriginal HIV/AIDS issues. The second part of the meeting discussed the development of a holistic Aboriginal peer health model. Details of the meeting have not been released.

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[42] *HIV/AIDS in Prisons: Final Report, Joint Project on Legal and Ethical Issues (Montreal: Canadian HIV/AIDS Legal Network, Canadian AIDS Society, 1996)*: IV

[43] Gina Whiteduck, Director General, Aboriginal Issues, Correctional Services Canada. *Aboriginal People and HIV in Prison*, sponsored by the Manitoba Aboriginal AIDS Task Force, Corrections Manitoba Council of Elders, and Simon Fraser University. Funded by the National AIDS Strategy, Health Canada, Correctional Services Canada (n.d): 11.

[44] *Aboriginal People and HIV in Prison*, sponsored by the Manitoba Aboriginal AIDS Task Force, Corrections Manitoba Council of Elders, and Simon Fraser University. Funded by the National AIDS Strategy, Health Canada, Correctional Services Canada (n.d)

In summary, since the ECAP *Final Report* was released in 1994, CSC has implemented bleach kits, condoms, lubricants and dental dams in prisons. A needle exchange pilot study is scheduled to occur in 2000-01. And, CSC has recently undertaken to respond to ECAP's recommendation on the issues of HIV and Aboriginal inmates by calling together the key players in Aboriginal HIV/AIDS issues to develop a 5 year plan for an Aboriginal-driven Harm Reduction program in federal prisons.

6.8 A final word on HIV and Prison Issues

When asked "What do you think is missing regarding the programs for Injection Drug Users", a respondent states, "Needle Exchange programs in prison. The habit will never cease, so may as well make things safe." CAAN will urge CSC to make clean needles available as soon as possible.

7.0 The Mobility Issue

7.0 The Mobility Issue

Outsiders may perceive injection drug use to be a problem restricted to downtown urban areas. This is not true. Pockets of injection drug use have been found in rural areas[45] and on Reserves. IDUs are highly mobile people who move between various urban centers and rural areas. The major concern is that Aboriginal IDUs may be unable to protect themselves and others from HIV infection when they visit their Reserve and have sex or share needles.

Exact figures for Aboriginal mobility are unavailable. The 1992 *Aboriginal Peoples Survey* found that 81% of Aboriginal people over the age of 15 had moved at least once over the course of their lifetime and that 15% had moved within the year prior to the survey.[46] Given that census data is biased towards people with fixed residency and limited in its inquiry, the numbers and reasons for Aboriginal mobility remain unclear. A study of 27 Aboriginal people living with HIV/AIDS (PHAs) by *2-Spirited People of the 1st Nations* found that 77% of this group had visited their Reserve since being infected with HIV.[47]

To address questions about the mobility of Aboriginal IDUs, the respondents (excluding those in jail) were asked: "How often do you visit your home community?" The wording "home community" may have generated some confusion for certain respondents as 7% did not answer this question. Fourteen percent (14%) report that they never visit their "home community." The remaining 79% of IDUs report visiting home communities for varying periods of time with varying frequency. Twenty percent (20%) of the respondents visit their home community more than twice a year, 23% visit once or twice a year and 36% of the respondents visit less than once a year. The duration of visits was reported by 32% of respondents as "a few days," and another 32% as 1 to 2 weeks. Seven percent (7%) stay only weekends but another 7% stay approximately 6 months. Finally, 5% of the respondents who answered the question stay in their home community

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[45] Remis, R., M. Millson, C. Major, "The HIV Epidemic Among Injection Drug Users in Ontario: The Situation in 1997", prepared for the AIDS Bureau, Ontario Ministry of Health, July 1997: 3.
[46] Statistics Canada, "Schooling, Work and Related Activities, Income, Expenses, and Mobility," ABS, cat no. 89-534: xvi.
[47] Gilbert Deschamps, Michael Thoms, *Mino-Waakaa'igun: a proposal to provide a Supportive Housing Facility for Aboriginal People living with HIV/AIDS*, prepared for *2-Spirited People of the 1st Nations*, June 28, 1995.

for 1 to 2 months. Of the 36% of the respondents who visit their home community less than once a year, they generally report visits lasting from 1 to 2 weeks when they do visit home.

These numbers suggest that 79% of the Aboriginal IDUs in this survey interact with their home community, whereby 43% of the respondents are home at least once a year and another 36% are visiting less regularly. The majority of the visits are less than 2 weeks in duration.

The problem is clear. Aboriginal IDUs are at very high risk of HIV infection on the streets and in jail. These people do not live in a vacuum -- they visit their Reserves with some frequency. Anecdotal evidence suggests that they may be having sex and/or sharing needles on their Reserves during visits. Few Reserves have condom distribution or needle exchange programs to reduce the risk of HIV infection among people in the community. The potential for an HIV epidemic spread by sex in an Aboriginal Reserve community is very real.

8.0 Predictors for HIV Sero-Conversion

8.0 Predictors for HIV Sero-Conversion

Health experts have isolated a series of indicators for predicting people with a high probability of contracting HIV (sero-converting). Determining which groups in Canada are at a high risk of HIV infection helps service providers target education, prevention and care programs. As will be shown, most of the 126 Aboriginal IDUs that answered our questionnaire are at a high risk of sero-conversion.

STDs		
	Number in the Sample	% of the sample or subgroup
STDs		
Persons with STDs	63	50%
Men with STDs	24	39%
Women with STDs	38	60%
Transgender withSTDs	1	100%
Sex trade workers with STDs		
Women	31	69%
Men	1	50%
Transgender	1	100%

First, the general Aboriginal population is at a high risk of HIV infection due to lower condom use, high levels of STDs, poverty, low self-esteem, substance abuse and high levels of sexual abuse. STDs increase people's receptiveness to HIV and also indicate unsafe sex practices. Some studies suggest that Aboriginal STD rates are 5 to 10 times higher than non-Native rates.[48] In our sample 60% of the women and 39% of the men have or have had an STD. Among sex trade workers, 69% of females and 50% of males in our sample have or have had an STD.

In terms of Aboriginal people who use injection drugs, the likelihood of these individuals contracting HIV climbs even higher than among the general Aboriginal population. Health researchers and HIV/AIDS epidemiological experts have determined that the following social determinants are independently associated with HIV sero-conversion: low education, unstable housing, sex trade work, sharing needles, being an established IDU, injecting with others, frequent NEP attendance, previous imprisonment and cocaine as the injection drug of choice.[49] These social predictors for HIV sero-

[48] Health Canada, Bureau of HIV/AIDS and STD Update Series, (Laboratory Center for Disease Control), "HIV/AIDS Epidemiology Among Aboriginal People in Canada", *HIV/AIDS Epi Update*, November 1997

[49] Strathdee, S., D.M. Patrick, S. L. Currie, P.G.A. Cornelise, M. L. Rekart, J. S.G. Montaner, M.T. Schechter, and M.V. Oshuagnessy, "Needle Exchange is not enough: lessons from the Vancouver injecting drug use study", *AIDS* 11 (1997): F59-F65;

conversion indicate that the 126 Aboriginal IDUs who responded to our questionnaire have a high probability of HIV sero-conversion because their housing is unstable, formal education is low; the incidence of their involvement in sex trade work is very high; cocaine is the drug of choice; needles are shared; 87% have been imprisoned at one time; they frequently attend NEPs; and STDs are very prominent.

Frequent NEP attendance has been listed as one predictor for sero-conversion and this should be explained. It has been concluded in a series of studies around the world that NEPs are effective at curbing the spread of HIV. As one researcher explains, "In Montreal, the Cactus exchange reported a decrease in use of dirty needles from 37 per cent to 26 per cent over six months, and an increase in cleaning (with bleach) from 83 per cent to 93 per cent of occasions. The Edmonton exchange reported that the longer users attended the service, the less likely they were to practice risky behaviours such as sharing of dirty needles."[50] Health Canada states, "There is evidence that NEPs prevent HIV infections among IDUs and do not increase the number of IDUs or lower the age of first injection". Further, in places like New York City where NEPs have not been fully

Predictors for Sero-Conversion	
	Data from the 126 Respondents
Unstable housing	44% without stable housing
Low education	56% below grade 10
Sex trade	71% of Women
Injecting with others	Undetermined
Cocaine as the drug of choice	61% use Cocaine
Previous imprisonment	90% among Men 84% among Women
Sharing needles	36% share needles on the streets 82% share in prison ?% share on Reserve
STDs	50% of the sample
Irregular condom use with non-regular partners	42% for Women 48% for Men

Bruneau, J., F. Lamothe, E. Franco, N. Lachance, M. Désy, J. Soto, and J. Vincelette, ""High rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study:, *American Journal of Epidemiology* 146.12 (1997): 995.

[50] Riley, Diane, *The Harm Reduction Model*, (Ottawa: Canadian Centre on Substance Abuse, no date): 3.

legalized, the HIV rate among IDUs has reached 60%.[51] Despite the strengths of NEPs, a Vancouver study has stressed that "needle exchanges are not enough" and that counseling, referral and support services must also accompany NEPs so that people can be encouraged to change behaviours which place them at risk of HIV infection.[52] This Vancouver study and a Montreal study[53] found that one characteristic of people who are likely to sero-convert is regular NEP attendance. However, the results of these two studies have been misinterpreted by some politicians and community groups in both Canada and the United States in order to support the argument that NEPs contribute to a rise in the infection rate. This is untrue. Frequent NEP attendance is listed as a predictor of HIV sero-conversion not because NEPs increase risk of HIV infection, but because the people who access these services are plagued by a host of social and economic problems which automatically place them in a higher risk group. The principal researcher in the Vancouver study told a reporter, "Our results have been misinterpreted....The rate would have been higher in the first place without the needle exchange. The needle exchange should be viewed as the cornerstone of HIV intervention."[54] In effect, NEP attendance does not increase a person's risk of HIV sero-conversion, but instead empowers IDUs to protect themselves and reduce the risk of HIV infection .

It should be noted that this list of independent predictors for HIV sero-conversion is composed of two broad contexts: 1) socio-economic and 2) behavioural. Over the long-term we may help Aboriginal IDUs reduce the risk of HIV infection by lobbying for improvements in their socio-economic position (i.e. housing, income). This will help Aboriginal IDUs break the cycle of crime and hustling which presently shapes their lives and places them at risk of HIV infection. We can also help Aboriginal IDUs reduce the risk of HIV infection by helping them make informed decisions about behaviour which may put them at risk of HIV sero-conversion and by providing the Harm Reduction programs (i.e. condoms and needle exchanges) which will help them protect themselves wherever they happen to be.

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[51] *Ibid.* 3
[52] Strathdee, *ibid.*: F59-F65.
[53] Bruneau, J., F. Lamothe, E. Franco, N. Lachance, M. Désy, J. Soto, and J. Vincelette, ""High rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study . *American Journal of Epidemiology* 146.12 (1997): 995.
[54] Robert Sarti, "City's HIV infection rate falls", *The Vancouver Sun*, Saturday, April 11, 1998: A5.

9.0 Harm Reduction

9.0 Harm Reduction

This section explains the Harm Reduction approach and philosophy in depth and integrates this information with the comments and views received from the 126 Aboriginal IDUs. Barriers to existing services are reviewed. the importance of a culturally appropriate models is discussed and this section concludes with the examples of 2 Reserves in Saskatchewan which have implemented Harm Reduction programs to reduce the risk of HIV transmission within their communities.

9.1 What is Harm Reduction?

There has been a long debate about cocaine, heroin and other forms of drug use. One side of the debate has argued that all drugs of this nature should be illegal and that society should use all of its resources to prevent illegal drug use. This side is known for its "war on drugs" and calls for total abstinence from drugs. The other side of the debate has argued that drugs should be decriminalized. This side has argued that the criminalization of drugs has created a dangerous underground control of the drug trade and that any "war" against drugs is futile and a poor use of society's resources. There was no middle ground between these two sides until 1990.[55]

In 1990, at a conference in Liverpool, England, medical experts from around the world developed the "Harm Reduction" approach which is a pragmatic, middle of the road perspective on drug use which focuses on reducing the harm caused by drugs as opposed to taking a stance on abstinence or decriminalization. The concept of Harm Reduction has largely arisen because of the critical nature of the HIV/AIDS epidemic. Many experts now agree that preventing the spread of HIV is more important that "warring" against drug use. Typical Harm Reduction models involve condom distribution, needle exchange, and methadone maintenance programs.

Harm Reduction does not necessarily mean you condone drug use but rather, offers a pragmatic solution to stopping the spread of HIV. Harm Reduction programs

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[55] Erickson, Patricia G., Diane M. Riley, Yuet W. Cheung, Patrick A. O'Hare, "Introduction: the Search for Harm Reduction", *Harm Reduction: A new direction for drug policies and programs* (Toronto: University of Toronto Press, 1997):4-14.

have been widely applied in Britain and the Netherlands. In Canada, Health Canada has fully endorsed the Harm Reduction model and in 1989, the Government of Canada legalized needle exchange programs. Canadian healthcare systems also fund methadone maintenance programs to help heroin addicts reduce the harm of their addiction. As Riley states, "...the first priority of Harm Reduction is to decrease the *negative* consequences of drug use".[56]

IDU Attitudes Towards Behaviour Change

Because I want to change my lifestyle while I still have a life.

To keep me alive longer.

I feel that I have fucked around with my life long enough.

Harm Reduction is not a moralistic concept which takes a stand on drug use but rather, it is a pragmatic solution to the very serious issues of HIV infection. In fact, Harm Reduction is intended to be a value-neutral approach and makes no assumptions about drug use or persons who use drugs. The intention of Harm Reduction is to help drug users make informed decisions and empower themselves to reduce the potential harm from drug use.[57]

We know from our survey that IDUs do not want to contract HIV, they want to protect their partners and they already use NEPs and condom distribution (where available) to reduce the risk of HIV infection. The *National Action Plan* concurs with these survey findings:

> "Drug users can and do learn to use safer methods of injecting which can protect them, their partners, and their children from HIV. Some stop using drugs altogether. The right interventions, offered at the right time, do work. It is time to move beyond debating ideological differences and take full advantage of the knowledge and experiences already available. It is time to act."[58]

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[56] Riley, Diane. *The Harm Reduction Model*. (Ottawa: Canadian Centre on Substance Abuse, n.d): 1.
[57] Erickson, Patricia G., Diane M. Riley, Yuet W. Cheung, Patrick A. O'Hare, "Introduction: the Search for Harm Reduction", *Harm Reduction: A new direction for drug policies and programs* (Toronto: University of Toronto Press, 1997):4-14.
[58] *National Action Plan*: 10.

The goal of this project is to help CHRs and other Aboriginal health programmers develop a Harm Reduction program for their communities. When we do this it will help protect Aboriginal people from HIV infection and keep our communities healthy. Furthermore, it should be pointed out that IDUs do not inject forever and after some individuals quit, they may take up new roles in our communities. As the *National Action Plan* states:

> "People who inject drugs do not usually continue to do so all their lives. When they successfully stop injecting, society wants them to have years of productive life ahead of them. For this to happen, we must keep them healthy, HIV free, and alive."[59]

9.2 Summary of the Harm Reduction Philosophy

The basic tenets and philosophy of the Harm Reduction approach have been summarized in a recent book on Harm Reduction[60] and by the *American Harm Reduction Coalition* (AHRC).[61] These basic tenets and philosophies can be summarized as follows:

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[59] *National Action Plan*: 10.

[60] Erickson, Patricia G., Diane M. Riley, Yuet W. Cheung, Patrick A. O'Hare, "Introduction: the Search for Harm Reduction", *Harm Reduction: A new direction for drug policies and programs* (Toronto: University of Toronto Press, 1997):4-14.

[61] *American Harm Reduction Coalition* , mimeograph (October 1993).

The Basic Tenets and Philosophy of Harm Reduction[62]

from: Erickson, Riley, Cheung, O'Hare, 1997, and
***The American Harm Reduction Coalition* (1993)**

1. "A value-neutral view on drug use"
   - There are no moral, legal, or medical judgments made about drug use. Drugs are not be debated as good or bad, moral or immoral.

2. "A value-neutral view of the user"
   - There are no moral judgments made about the IDU because drug use is not seen as immoral or irresponsible.
   - the dignity and value of all human beings is respected

3. "Focus on the Problem"
   - The concern is the potential harm from injection drug use. The focus is the problem of reducing the potential for HIV infection among IDUs.
   - The Harm Reduction approach provides options in a non-judgmental and non-coercive way.

4. "The irrelevance of abstinence"
   - The focus is not on abstinence. Harm Reduction accepts that IDUs will continue to use drugs. However, abstinence can be part of the program for IDUs who want to quit using drugs. But abstinence is not the goal; reducing harm from drug use is the relevant goal.

5. "User's role in Harm Reduction"
   - Harm Reduction recognizes that the IDU is capable of making their own decisions and should be empowered to make their own decisions through access to information and the means to protect themselves. The participation of the IDU is a key component of Harm Reduction.
   - In short, IDUs are competent to make choices and change their behaviours

6. "Community Involvement"
   - The AHRC: "demands that the individuals and community affected by drug use be involved in the creation and implementation of Harm Reduction interventions"
   - The programs should be holistic – they should understand the individual's whole relationship to drug use and not simply treat the symptoms.
   - the programs should be flexible at the community level.

[62] This chart paraphrases the ideas and bulleted points detailed in the 2 previous footnoted sources. Please see footnotes 60 and 61 for further elaboration.

9.3 Existing Services: Aboriginal AIDS Services, Needle Exchange Programs

Condom distribution programs are common in most health clinics. Needle exchange programs (NEPs) were legalized in Canada in 1989. By 1994 there were 235 NEPs operating across the country. Methadone maintenance treatment is explained below (Section 9.4).

Aboriginal people have been involved in preventing the spread of HIV/AIDS since the late 1980s. Today, culturally appropriate AIDS education and prevention information is provided by Aboriginal people at the national level through the Canadian Aboriginal AIDS Network (CAAN) and at the provincial level by a series of provincially funded organizations. Phase II of this project will explain how you may better link with these Aboriginal AIDS organizations.

Needle exchange programs have traditionally been provided by street-based health agencies and not specific Aboriginal organizations. NEPs in major cities across Canada (i.e., Vancouver, Edmonton, Winnipeg, Toronto and Montreal) have done an outstanding job of preventing the spread of HIV in the IDU community. These service providers have established the trust of their clients and have been the center for some important research on HIV and IDU. Most NEPs have an Aboriginal clientele but it is hard to know what level of cross-cultural training exists for NEP workers. Despite the tremendous success of NEPs, some barriers continue to exist in the provision of clean needles, condoms and information to Aboriginal IDUs. In particular, urban NEPs are not equipped to prevent HIV transmission on Reserves or in the other places to which Aboriginal IDUs travel.

9.4 Existing Services: Methadone Maintenance Treatment

Methadone is an orally administered, long-acting synthetic opioid which is prescribed to IDUs who are addicted to heroin and/or other opioids in order to block the euphoric effects of the drug, thereby allowing for gradual addiction withdrawal. The main benefits of methadone include: an 85% success rate in treatment of the opioid addiction;[63] a reduction in IDU infection transmission, especially HIV; and reduced

[63] Berger, Philip, "Methadone Maintenance Programs", (mimeograph, n.d.).

criminal activity and mortality.[64] Although some consider methadone treatment to be the "replacing of one addiction with another", it is important to note that this treatment's minimal adverse side effects and its limited patient costs allow patients to exit a life of crime and follow new paths in life. Physicians are currently authorized by a federal licensing agency to prescribe and monitor methadone treatment. The cost to the health care system, including mandatory urine testing and patient treatment programs, is approximately $6000 per patient per year.[65] More specific information on methadone maintenance will be provided in Phase II of this project.

[64] Isaac, Pearl et al., "Methadone Maintenance: The Pharmacist's Perspective", Pharmacy Connection (September/October 1994): 26-33)
[65] Berger, Philip, "Methadone Maintenance Programs", (mimeograph, n.d.).

10.0 The Respondents and Harm Reduction

10.0 The Respondents and Harm Reduction

10.1 The Present Health of Those Sampled

Among the 126 Aboriginal IDUs surveyed, the majority (60%) report themselves to be in good health and 23% access themselves to be in medium health. Only 14% report to be in poor health. Respondents appear to base their self-assessment on recent medical check-ups. Reasonable access to regular medical check-ups is reported by the majority of the respondents with the exception of those from Alberta who appear to have significantly decreased access to regular medical check-ups.

10.2 Quitting

IDUs do not use forever. Many IDUs quit injecting drugs and take up other paths in life. 63% of this sample have attended a drug treatment center in an attempt to quit using drugs. 10% of the sample have already quit using injection drugs. All 12 Aboriginal IDUs presently serving jail sentences have tried to quit on their own. Most said that they have tried to quit "many times" or "lots". Clearly, a large majority of the 126 Aboriginal IDUs have attempted to quit using injection drugs. However abstinence is not the goal of Harm Reduction.

Why quitting is not relevant
Because I am not ready to quit.
Because I enjoy using.
I never thought that I needed to go into a program yet.
Didn't think I needed it.

Drug use must be treated as normal. Some people in the sample group do not want to quit because they do not feel that they have a problem or because they enjoy injecting drugs. These views are normal and need to be respected.

However, abstinence can be part of the program for IDUs who want to quit using drugs and we should help those who want to quit.

10.3 Barriers to Services

In order to help us identify the existing barriers to services and develop a Harm Reduction model, the 126 Aboriginal IDUs were asked a series of questions about barriers and unmet needs.

10.4 Abstinence: A Barrier to Drug Treatment Centers

Presently, 74% of the sample find existing drug treatment centers to be suitable, but improvements are necessary. As one respondent states, "...the programs that exist aren't reaching/aren't working." The primary difficulties with existing drug treatment centers are: that the focus is on quitting or abstinence; that the centers do not understand injection drug use addictions; and that the centers do not have cross-culturally trained staff.

Why existing drug treatment centers are not suitable for Aboriginal IDUs

"Not Indian enough", "Not Native enough", "run by the white man".

They don't know anything about needle use.

Because they cut you off from your freedom.

Not appropriate for transgender community.

Length of stay was longer than 4 weeks, waiting list too long.

You need some for youth. We have different problems and issues [female 16 years].

There aren't enough.

Lack of faith in confidentiality.

The issue of abstinence is a significant barrier to Harm Reduction. Most treatment centers currently require their clients to be drug-free for a period of time before entry. For many people this is difficult or unreasonable. Secondly, the abstinence model does not teach the large number of people who do not rehabilitate how to reduce the harm associated with injection drug use. As one respondent states, there is too much emphasis on "curing."

Respondents have commented that the existing treatment centers are "not Indian enough" or "run by the white man." Some Aboriginally run treatment centers do exist but again, the problem is that the centers are built on the abstinence model. Several of the respondents expressed frustration and negative experiences with these Aboriginal abstinence programs.

The attitude and bias of service providers and the unreasonable focus on abstinence are expressed in this comment by one respondent:

> "There is a middle-class expectation that I want to forget my past and adopt the counselors' ethics, principles, style of dress, and speech. [To] become middle-class when I quit dope. To quit is the only way they care. [It is the] only basis for deciding success. If you use, you are out. No more help."

Another respondent states:

> "I'm sick of counselors saying "you chose your lifestyle", "you weren't ready for the program", or "it's too bad you lost 8 months because you used last night". It is never them or the place, unless it's successful. Otherwise it's the client's fault or responsibility."

Another respondent states:

> "Forget the 12-step program and focus on the individual. Sometimes people just need to know that they are cared about. Sometimes rules and regulations don't help. Everyone does not need a program."

It is clear that treatment centers which do not require abstinence as a condition of entry and which make the reduction of harm from injection drug use part of their goal are needed. As one respondent stated, "...treatment centers have to change to be effective." Treatment centers can work and are very important. As one respondent stated, "...when I was younger, there wasn't anywhere to help me until now. I wouldn't have gotten as bad."

10.5 General Barriers

The 126 Aboriginal IDUs that responded to the questionnaire were asked about the barriers which prevent them from accessing health, social and cultural services. From their answers it is clear that Aboriginal IDUs face a series of barriers which are common to all IDUs, but they also experience an additional set of barriers which come from within

their own communities and culture. The barriers experienced by the 126 respondents may be identified as:

1. **Structural or Institutional Barriers**
2. **Abstinence Expectations**
3. **Issues of Labels and Stigma**
4. **Internalized Shame and Personal Obstacles**
5. **The Attitude of Service Providers**
6. **Lack of Cultural Awareness Among Service Providers**
7. **Internal Community and Cultural Barriers**
8. **Confidentiality**

These Barriers can be elaborated as follows:

1. **Structural or Institutional Barriers**: The majority of the respondents have no difficulty accessing urban needle exchanges and condom distribution centers. Outreach programs and needle exchange vans are also well received and very accessible to the respondents. The majority of the respondents also report that hospitals and health centers are accessible but the most consistent complaint with provincial health services is the long waiting lists to see a doctor. Racism and stigma are two of the primary reasons that Aboriginal IDUs under use existing health services (see below).

The institutions with the least accessibility and the greatest barriers are drug rehabilitation centers, services in prison and services on Reserves. In terms of drug rehabilitation centers, the respondents identify the shortage of centers and long waiting lists as significant barriers to access. In prisons, the respondents state clearly that the prison prevents them from having access to cultural services, clean needles and information on Harm Reduction. On Reserves, many respondents state that the Reserves do not offer needle exchanges and that the communities are uneducated about the issues faced by IDUs. Living in the city is cited as a structural obstacle to accessing cultural services.

2. **The Abstinence Model**: As discussed above (section 10.4), the focus on abstinence is one of the IDUs most fundamental barriers to treatment centers and some health services.

3. **Issues of Labels and Stigma**: One of the biggest issues faced by Aboriginal IDUs is labels and stigmas. Native peoples already face racist stereotypes and for Aboriginal IDUs, the stigma of drug use, the pathologization of them as HIV carriers and the label of criminality further marginalize them from society and social services. As the *National Action Plan* states, "Continuing marginalization and stigmatization of injection drug users remain barriers to progress".[66]

Worst Experiences with Health Care
They told me I was a pig.
I am treated like a leper.
Being judged and made to feel like dirt when I was asking for help. Because I disclosed I was using drugs, I was refused help until I became totally abstinent.
The health care system don't care about junkies.

Labels and stigmas have made hospital care uncomfortable and underutilized by Aboriginal IDUs. One respondent explains:

> "I went to St. Joe's for surgery. I never told them I was wired on junk. A nurse saw my track marks and got cold to me. [There was a] big change in attitude. When I came out from the anesthetic, I asked for pain [pills] -- she said get dressed and gave me a script. I couldn't walk but I was out the door like that anyway, in a wheelchair. I phoned my dealer. He said to get a cab and he'd help me."
>
> "Why would they punish me at a hospital for being sick? But I know they did. If I told the truth, that I'm a junkie, they would postpone the surgery. So I took the chance of not telling them. They were all righteous, in case, I wonder, they get sued? They were in a huddle after she saw the tracks -- whispering, glaring over at me."

[66] *National Action Plan*: 13.

In a study by *2-Spirited People of the 1st Nations*, a large number of Aboriginal people living with HIV/AIDS had difficulty accessing health care. Forty-eight (48%) of those surveyed felt they received disrespect because of their culture and lifestyle in mainstream hospitals and health centers. As a result, many respondents reported a distrust of hospitals and health clinics.[67] A Vancouver study found that Aboriginal people with AIDS access health care and social services at a much later and at more acute level of AIDS related illness than do non-Natives.[68]

4. **Internalized Shame and Personal Obstacles:** When asked "what are some of the barriers preventing you from seeking out an Elder", many answered "shame." Although the reasons for their addictions are often outside of their control, many IDUs blame themselves for their situations and have internalized this shame. This internalized shame is bolstered by the stigmas and labels applied by their communities and outsiders alike.

5. **The Attitude of Service Providers**: Many respondents state that they experience a negative attitude by hospital staff, health care workers, the police and prison officials. "I feel frustration from the service providers and [that] I am being judged." said one respondent. Again, the focus on abstinence and the negative attitude towards drugs by society is cited as a barrier to seeking the help of service providers.

6. **Lack of Cultural Awareness among Service Providers**: Many respondents state that the services are inaccessible or ineffective because they are geared to Western culture.

7. **Internal Cultural Barriers**: Aboriginal IDUs also face significant discrimination and stigmatization from their own communities. Some feel that their communities are punishing them for their behaviour. Many respondents state that the

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[67] Gilbert Deschamps, Michael Thoms. *Mino-W'aakaa'igun: a proposal to provide a Supportive Housing Facility for Aboriginal People living with HIV/AIDS*, prepared for *2-Spirited People of the 1st Nations*, June 28, 1995

[68] Sanderson, Barbara, and Bonnie Gabel, "Evaluation of The Native AIDS Coordinator Program: A Joint Project of the Vancouver Native Health Society and St. Paul's Hospital", (Vancouver: 1994).

Reserve community does not understand them and that they feel rejected by the Reserve community.

Several Reserves in the Canada have been trying to engage in a "war on drugs" which is designed to stigmatize and shame drug users in the community. The implementation of Harm Reduction services on any Reserve which refuses to be pragmatic about drug use will be very difficult. In another context, a respondent states:

Barriers to Seeking out an Elder
I'd feel ashamed about my drug habit.
My drug addiction drinking, not knowing one.
Lack of knowledge, busy, no time, and addictions.
Right now because of my drug use, out of respect. I will not see an Elder unless I am clean.
Walls and bars [incarcerated].
Don't know how to get a hold of an Elder in the city.

"It has been my experience of knowing... some individuals who have contracted HIV and who live or have fallen to this disease that were abandoned by family and friends. In my experiences it has been the First Nations/Aboriginal communities that have been the hardest and [most] unaccepting of their own community [members] in regards to this [HIV].

I feel that it is unacceptable to abandon people because they have made a mistake in their life."

8. **Confidentiality**: A very significant barrier to accessing health care services on Reserves is confidentiality. The problem of confidentiality in health issues is a problem which has been noted in repeated studies. Reserves are close-knit communities where the community nurse, CHR or secretary is often a relative or friend. Accessing services for stigmatized programs such as clean needles or HIV testing is unimaginable for some IDUs on Reserve. As one respondent states:

> "CONFIDENTIALITY [is] absolutely a must. Some of the workers may be a relative and I would feel uncomfortable to disclose some of my issues, for example sexual abuse."

10.6 What is Missing from Existing Services

The respondents were asked, "What do you think is missing regarding the programs for injection drug users?". The most repeated points were: that existing centers do not provide enough information about injection drug use; that there is not enough personal counseling and follow up services; that more cultural awareness is necessary; that methadone is not being made available; and that the hours of service should be improved. It is frequently stated that what is needed are Aboriginal counselors who have personal experience with street life and IDU are needed.

What is missing in Programs for IDUs
1-on-1 counseling.
Elders.
Methadone program to wean yourself off.
Programs just for IV [IDU] use.
Compassion and understanding
Follow up programs.
Counselors who have experienced the use of needling

There is a clear interest among the respondents to hear from guest speakers who have experience with the streets and IDU. When asked to provide suggestions for a "traditional addictions program", many respondents stated: "lots of guest speakers", "more speakers, people who went through it", and that, "it should be run by First Nations people... that have lived the lifestyle". Finally, it was stated that the people involved "must be serious" about helping.

10.7 The Importance of Culture and Aboriginal-Driven Services

The principle for Aboriginally-driven AIDS education and service provisioning is that culturally appropriate HIV/AIDS services will be more effective. The responses of the sample of 126 Aboriginal IDUs confirms a higher likelihood of success for HIV/AIDS services which are Aboriginal-driven and culturally appropriate. When asked, "do you think culture is important when dealing with this illness [HIV/AIDS]?", 84% of the respondents answered yes. Some reasons were: "because it gives you strength and hope" and " because it helps to bring community together". 79% of the sample claim they would utilize an Aboriginal-specific service for HIV testing and HIV/AIDS information if one was available. The reason is clearly about being "more comfortable with my own people." One respondent explains all the silent and intangible reasons why services for Aboriginal people should be provided by Aboriginal people:

Do you think culture is important when dealing with HIV/AIDS?
Because it helps to bring community together.
Yes, some people need spiritual help to cope with the illness.
I think we should support our people who have this, so culture is important. You are dying, you don't want to loose your culture too.
For the reason being it gives the individual hope. Also if the community is aware they will not be ignorant towards that person's illness.

> "To have someone who shares the same social background and similar experiences and belief system means some unsaid communication can begin healing the spiritual hurt that is part of HIV."

Cultural Comfort with an Aboriginal AIDS service provider
I would be more comfortable with my own people.
I'd rather deal with my own people and talk to people who are there for their brothers, rather than a white man's program for white people.
Because it is a support group governed by my people designed to help us all through tough times where STDs are a fact of life. Which unfortunately affects us all in one way or another.
For one, I would feel comfortable talking to Native people, and being tested, counseled by Native people cause I feel they would be more understanding and accepting.
Because I am Native and I think people should stand by their kind.

In terms of traditional cultural activities (i.e., sweats, healing circles, teachings), the respondents generally think that these activities are important. Eighty percent (80%) of the respondents would find an Elder helpful and 78% would use the services of an Elder. Issues of internalized shame and fear about approaching an Elder will have to be addressed first. Most respondents feel that these traditional cultural services should be blended with western addiction and Harm Reduction services.

Many members of the sample group were careful to state that culture should not be forced on anybody. Others stated that the priorities in services should be on housing and skill development, before cultural programming.

> "I feel a traditional addictions program should first and foremost deal with the person in the most critical areas, i.e. health issues, clothing, nutrition, and housing. I feel spirituality has a place for everyone, but in different ways and at different times and should not be superimposed on any one. Compassion and to be non-judgmental are critical to dealing with addictions issues. It should deal with addiction, somewhere to live, and life skills and then culture."

Would an Elder be Helpful?
Very much. A lot of Native people that I have met have asked if I know where they can find an Elder but I have no answers.
Yes, to help and guide people to their path, healing and basically finding balance.
Yes if he was able to point me into a way of living a drug free life.
Because Elders always know more. They have lived longer and know more how to live. They have experienced a lot more. I think Elders we learn from and children are our future.
Elders in my experience always have a lot of strength and wisdom and would know if coming would be right. But Elders are always helpful.
But like many other things, I feel it has to be the right person.

10.8 The Rationale: Why We Should Offer Aboriginal Harm Reduction Programs

The 126 Aboriginal IDUs provide 3 strong reasons why they would use an HIV testing program and services from an Aboriginal AIDS service organization:

Improved Access to Information
I want to find out more about AIDS and HIV. It would really help me.
To feel safe and know if I have HIV or AIDS.
So I could be more aware
Because it would help educate me.
Every one must know what they can about AIDS.

1. To get HIV/AIDS information.
2. IDUs will make will change their behaviour after receiving both HIV/AIDS information and HIV test results
3. This information will help IDUs protect others from infection. For example, one person said he wanted to know his HIV status "for the safety of my family."

Thus, if the goal of Harm Reduction is to help empower Aboriginal IDUs to make behaviour changes which reduce their risk of HIV infection and the spread of the virus. these 3 responses by the 126 Aboriginal IDUs suggest that they will embrace this goal.

How HIV test results and HIV/AIDS information will help IDUs protect themselves and others
So I can understand a lot more about the virus and I'd like to know if I ever did get sick so I can be careful not to pass the virus on to anybody else.
Because I would like to know if I did contract it, if I could protect my girlfriend.
To know where I stand in life and for the respect of others.
I have been tested and been careful since for my and my children's sake.

10.9 Two Successful Harm Reduction examples from Saskatchewan

In Saskatchewan, the Beardy's and Sandy Lake First Nations have established bi-weekly outreach HIV and STD testing clinics. The clinics are not part of the Band or Tribal Council's operations. They are staffed by employees of the provincial Prince Albert Health District (PAHD) and funded by the Government of Saskatchewan.

Each First Nation is about an hour drive from the city of Prince Albert where the PAHD has a central health center. In 1996, the Community Health Nurse (CHN) and Community Health Representative (CHR) at Sandy Lake wrote to the PAHD and inquired about establishing an HIV clinic with the First Nation. A PAHD nurse explains that the Provincial Government of Saskatchewan was pleased to allow the linkage and no jurisdictional debates over funding occurred. For the first year the nurses conducted an HIV and STD educational campaign at Sandy Lake by attending sessions to which they were invited. These interactions developed trust between the community and the nurses. In the second year a confidential bi-weekly outreach clinic was begun. It provides

anonymous HIV testing as well as testing for Chlamydia, Gonorrhea, Syphilis, Herpes and Hepatitis B and C. The clinic also provides counseling, condoms and referrals to other services.

There have been no concerns in the community that the clinic is encouraging sex and members of the community recently staged a theater presentation on HIV and AIDS.

The biggest barrier to be overcome by the clinic was the concern about confidentiality. As explained in the analysis above (section 10.5.8), Reserves are close-knit communities where the CHR or clinic secretary is often a relative or friend. Accessing services for stigmatized programs such as HIV testing is unimaginable for some people on Reserve. Confidentiality has not been a barrier to the operation of the clinic at Sandy Lake for 3 reasons. First, the clinic is staffed by an outsider and the testing records are not kept on site. Secondly, the clinic is connected to the school where it can be discretely accessed by students. The office itself is private. Third, the nurse and outreach workers have gained credibility and trust in the community. Indeed, community cooperation between Reserve staff, the CHR and the nurses has been very good. As one brief report states, "Crucial to the success of the program, is trust in the individuals providing the service along with strong community commitment, cooperation and ownership".

A similar bi-weekly clinic began at the Beardy's First Nation last June, 1997. In this community a popular teacher was living with HIV and helped to raise awareness about the disease in the community. As one person has said, the community "was ready" for an outreach clinic and HIV testing program. The community recently secured funding from Medical Services Branch, Health Canada, to conduct a needle exchange program.

Again, the program in this community is successful because of the increased awareness about HIV; the building of trust between the provincial nurses and the community; and by the alleviation of confidentiality concerns through the use of outsiders, private offices and off-site record keeping. The program is also successful because of the generous funding of the Government of Saskatchewan and the Prince Albert Health District which have not chosen to create jurisdictional arguments against funding the programs and staff.

11.0 Conclusions and Recommendations

11.0 Conclusions and Recommendations for the Implementation of an Aboriginal Community Harm Reduction Program

Phase I of this study has identified the problem of HIV and Aboriginal injection drug use. This analysis has been informed by the views of 126 Aboriginal IDUs from across Canada and within 2 federal prisons. Phase I has also included an identification of the barriers to implementing a Harm Reduction program in Aboriginal communities across Canada. It is recommended that a second phase (Phase II) provide more specific information about how to link with regional health authorities, acquire needles, establish methadone programs and secure funding for community-based Harm Reduction programs.

It is recommended that the three main components of an Aboriginal community Harm Reduction program be condom distribution, needle exchange and methadone maintenance treatment. It is highly recommended that abstinence not be the focus of these programs. Culture is important, should be part of the program and needs to be determined at the local level. It is recommended that the issues of confidentiality be overcome where necessary, by the use of outside nurses and off-site record keeping.

The program must be: non-judgmental, pragmatic, flexible and recognize the IDUs' ability to make their own informed decisions. Speakers who have been through street life and IDU will be important in the selling of the program to each community.

APPENDIX A

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This paper is the collective opinion of the Board of Directors of the *Canadian Aboriginal AIDS Network*. A list of the directors is included in Appendix A.

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The Board of Directors would like to acknowledge the contributions of Dorothy LaPlante for interviewing126 Aboriginal injection drug users. Her patience and ability to gain the trust and support of an often hard-to-reach group of people has made this paper unique and innovative.

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